

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>005044</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/14/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>REID HOSPITAL &amp; HEALTH CARE SERVICES</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 REID PKWY RICHMOND, IN 47374</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of a State complaint.</p> <p>Survey Type: Licensure complaint IN00101496 Unsubstantiated, lack of sufficient evidence.</p> <p>Date of Survey: 05-14-12</p> <p>Facility number: 005044</p> <p>Surveyors: John Lee, R.N. Public Health Nurse Surveyor</p> <p>Reid Hospital &amp; Health Care Services is in compliance with 410 IAC 15-1.5-6, Nursing services, Hospital Licensure Rules.</p> <p>QA: cloughlin 05/18/12</p>	S 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1